The anterior retractor has a difficult rôle to play, since the peritoneal reflection is higher than usual and is opened later. The irregularities of the tumor, too, can hinder progress and even prevent one from reaching the fundus when the peritonæum is reached. Small fibromata are frequently met with in the course of the operation; these can be gently removed, and usually can be drawn out with a pair of forceps. The right and left of the tumor can be grasped with strong forceps, and then bit by bit with long handled bistoury, or with scissors, the mass can be removed till finally the cornua can be drawn together and treated as before. Often, if the uterus is very large and globular, the greatest patience is necessary, as it is smooth, hard and slippery, and unless care be taken may slip away from the grasp. Extra and unexpected tumors may come to view, and the operation may be extended to two or three hours.

The ovaries and tubes should be treated as may be necessary, and the same rules hold as now given in the preceding section.

The results of these operations, often long and sometimes frightful to behold, the author claims to be surprisingly good and the reaction slight or entirely wanting, the patient usually having little pain and scarcely any rise of temperature.

H. P. DE FOREST.

SUGGESTIONS FOR EFFECTING SPHINCTERPLASTY AFTER AMPUTATION OF THE RECTUM.

CH. WILLEMS,[1] of Ghent, following von Hacker's idea of making the abdominal opening of a colostomy through the separated fibres of the rectus abdominis, in order that the patient may have a voluntary control over the bowel movements, has applied the same principle to the amputated rectum, using as the muscle of voluntary control the gluteus maximus. He proceeds as follows: When the amputation is not done especially high it not is difficult to draw

[1] Centbl. f. Chirg., May 13, 1893.

the stump well down into the wound. When this is done an incision 5 or 6 cm. long is made through the skin above the tuber ischii, passing upward and outward. This incision runs parallel with the fibres of the gluteus maximus, which can be felt with the finger in the extirpation wound. The muscle fibres are next separated by blunt dissection, making an opening about 2 cm. from the lower edge of the muscle. Through this chink the end of the gut is dragged and sutured to the skin.

If the amputation has been done higher, and it is impossible to bring the bowel down to this point, the opening through the muscle can be made higher up, in fact, through any fibres inserted into the edge of the sacrum. The operation has thus far not been performed upon the living subject, but has been practiced only on the cadaver.

R. GERSUNY,[1] of Vienna, has performed his new operation upon two cases of carcinoma of the rectum, in which the sphincter ani could not be preserved, although in both cases, after the diseased portion had been removed, the stump of the rectum could be drawn down to the skin surface. His operation consists in placing two clamps diametrically opposite to one another on the free end of the stump of the rectum. With these clamps he now twists the gut on its long axis until the finger to be introduced into the lumen of the intestine has to pass considerable elastic resistance. The gut so twisted is then sutured by its free end to the skin.

In both cases the wounds healed rapidly, and without the sutures giving way. During their stay in the hospital the first patient had no incontinence; the second was at first unable to control watery stools, but later regained a satisfactory continence.

Soon before they were discharged from the hospital examination showed a different condition from that immediately after the operation. At first it could be felt that the longitudinally folded gut, from below upward, gradually narrowed like a funnel; but the last examination showed a prominent annular constriction, from 2 to 3 cm.

[1] Centbl. f. Chirg., July 1, 1893.

above the external anal opening. This ring gave to the finger very much the same sensation as the normal sphincter ani. The rectum below this ring was cylindrical, and immediately above it the lumen of the gut was normal in measurement.

The one patient reported at the end of sixteen days after leaving the hospital, that he had perfect control over the bowel; the other reported, at the end of eleven weeks, that the function was entirely normal.

In the first case the torsion was carried to 180°; in the second it was carried to 270°. The bowels were moved on the fifth and sixth days respectively. Drainage was employed in both cases, and the wounds closed.

The mechanism of this narrowing of the lumen is accomplished simply by means of the torsion; and the extent to which it is carried must be governed by the finger introduced in the bowel. The operation is applicable not only to amputatio recti, but to every artificial anus; and also in cases in which an artificial anus has been made, and in which incontinence exists, the gut may be freed, twisted and again sutured to the surface opening.

JAMES P. WARBASSE.